Specialty Independent Review Organization

**Notice of Independent Review Decision**

**Date notice sent to all parties:** 5/12/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**
The item in dispute is the prospective medical necessity of lumbar epidural steroid injection.

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**
The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation.

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of lumbar epidural steroid injection.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

**PATIENT CLINICAL HISTORY [SUMMARY]:**
The injured worker sustained a work related injury to the lower back on xx/xx/xx. According to the records, he fell on his left shoulder and also injured his back. The shoulder injury was treated with physical therapy and an injection. There is no documentation in the submitted records that the worker received physical therapy for the back injury. Records indicate that requests were made for pre-authorization of lumbar ESI in 2102 and 2013 but the requested procedures were not authorized.

On 03/27/2014 the worker was seen regarding back and shoulder pain. The visual analog scale pain level was reported to be 9/10, with pain in the lower

back and left shoulder, muscle spasms, and with sleep disturbance due to pain. He was taking OTC medications, meloxicam and metformin. The past pain procedures listed were physical therapy for the left shoulder for one week without benefit and shoulder injection on the left around 06/2012. No therapy for the lower back was mentioned. The review of systems was positive for back pain. On the physical examination, straight leg raising was positive on the left. Muscle strength was reported to be 4/5 bilaterally secondary to pain. The neurologic exam revealed no focal deficits. The gait was significantly antalgic.

On 03/28/2014 Doctor submitted a Pre-Authorization Request/Procedure Order for lumbar epidural steroid injection. The requested procedure was non-certified.

04/24/14 the worker saw for outpatient follow-up visit. A previously requested MRI of the lumbar spine had been denied. The visual analog scale pain level was reported to be 9/10. The worker was taking meloxicam, metformin, Celebrex and gabapentin. On physical examination he was reported to be in no distress. He walked with an antalgic gait. The diagnosis was displaced lumbar intervertebral disk, unspecified thoracic/lumbar neuritis/radiculopathy, and pain in the shoulder. The plan was to continue Celebrex and gabapentin, to have EMG/NCV May 6, 2014, and to return for follow-up in 1 month.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

The records do not contain sufficient documentation that the worker meets ODG criteria for lumbar ESI, as noted below.

- The findings on physical examination and diagnostic tests did not meet the ODG diagnostic criteria for lumbar radiculopathy.
- The records do not contain sufficient documentation that the worker's pain had been unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).

Regarding ODG diagnostic criteria for lumbar radiculopathy:
According to the ODG Integrated Treatment/Disability Duration Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) (updated 03/31/14), pertaining to Epidural steroid injections (ESIs), therapeutic are

Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts.

As cited in the same (Low Back) chapter of the Guidelines: Andersson GBJ, Cocchiarella L, American Medical Association. Guides to the Evaluation of Permanent Impairment, Fifth Edition. Hardcover - Dec 15, 2000., radiculopathy (page 382-383) is defined as

a "significant alteration in the function of a nerve root or nerve roots and is usually caused by pressure on one or several nerve roots". The most important clinical components required to support the diagnosis of a compressive Radiculopathy include:

- Pain, numbness, and/or paresthesias in a dermatomal distribution
- An imaging study documenting correlating concordant nerve root pathology
- Associated clinical findings such as loss of relevant reflexes, muscle weakness and/or atrophy of appropriate muscle groups, loss of sensation in the corresponding dermatome(s)

Electrodiagnostic studies are helpful in supporting the diagnosis of a compressive radiculopathy but are not required, and do not substitute for imaging studies.

Regarding ODG Criteria for the use of Epidural steroid injections:
Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

(1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.
(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).
(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.
(4) Diagnostic Phase: At the time of initial use of an ESI (formally referred to as the “diagnostic phase” as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections.
(5) No more than two nerve root levels should be injected using transforaminal blocks.
(6) No more than one interlaminar level should be injected at one session.
(7) Therapeutic phase: If after the initial block/blocks are given (see “Diagnostic Phase” above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular

symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007)

(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.

(9) Current research does not support a routine use of a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.

(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.

Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.

The requested treatment is not medically necessary according to the ODG at this time.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

☐ **INTERQUAL CRITERIA**

☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TEXAS TACADA GUIDELINES**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**